Sign Language Interpreter Services Code Conversion: Frequently Asked Questions

HIPAA-mandated changes to billing requirements for sign language interpreter services will become effective on January 1, 2019.

HIPAA is the acronym for the Health Insurance Portability and Accountability Act that was passed by Congress in 1996. In addition to eliminating the use of HCPCS Level III local codes, HIPAA does the following:

- Provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs.
- Reduces health care fraud and abuse.
- Mandates industry-wide standards for health care information on electronic billing and other processes.
- Requires the protection and confidential handling of protected health information.

California has historically used thousands of HCPCS Level III or local codes (also known as interim codes) for billing and reimbursement of services and supplies. National codes, such as CPT Category I or HCPCS Level II codes are typically more specific in nature compared to local codes. Using HIPAA-compliant CPT Category I or HCPCS Level II codes will:

- Simplify the processes and decrease the costs associated with payment for health care services.
- Improve the efficiency and effectiveness of the health care system and decrease administrative burdens on providers (for example, medical practices, hospitals and health care plans).
- Provide standardization and consistency in medical service coding.
- Characterize a general administrative situation, rather than a medical condition or service, by using non-clinical or non-medical code sets.

HIPAA-compliant HCPCS Level II codes are required to bill for the service visit with the recipient on or after January 1, 2019.

The claim may consist of one of the following:

- HCPCS Level II code with modifier(s);
- Revenue code and HCPCS Level II code with modifier(s).

For dates of service on or after January 1, 2019, sign language interpreter service claims submitted with HCPCS Level III local codes will be denied.

Sign language interpreter services are a benefit to facilitate effective communication with deaf or hearing-impaired Medi-Cal recipients. Medi-Cal reimburses these services when there is communication needed between the Medi-Cal-enrolled provider and a deaf or hearing-impaired Medi-Cal recipient, a deaf or hearing-impaired adult representative of the Medi-Cal recipient, or a deaf or hearing-impaired adult who receives services or training on behalf of the Medi-Cal recipient. The Medi-Cal-enrolled provider must render the health care examination or health services provided to the deaf or hearing-impaired Medi-Cal recipient or the training for deaf or hearing-impaired adult representative as medically necessary.

The following Frequently Asked Questions (FAQs) will provide an overview of some of the changes occurring during this conversion.

1. What does the conversion from HCPCS Level III local codes to HCPCS Level II codes mean for billing sign language interpreter services?

Effective January 1, 2019, sign language interpreter services currently billed using the HCPCS Level III local codes will be replaced with HCPCS Level II national codes.

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2. What codes are changing in this code conversion?

Effective for dates of service on or after January 1, 2019, HCPCS Level III local codes Z0324 and Z0326 will be replaced with HCPCS Level II national code T1013.

Effective for dates of service on or after January 1, 2019, HCPCS Level III codes Z0328 and Z0329 will be terminated.

The national procedure code indicates oral interpretive services as well as sign language.

More information regarding local codes and national codes are located on the crosswalk on the HIPAA: Code Conversion page of the Medi-Cal website.

3. How will the conversion affect claims billed with dates of service prior to and after January 1, 2019?

Continue to bill with HCPCS Level III local codes for dates of service on or prior to December 31, 2018.

Begin billing HIPAA-compliant HCPCS Level II codes for dates of service on or after January 1, 2019.

4. What claim forms will I use to bill the national codes?

The national code in this code conversion may be billed on a *CMS-1500* claim form, an outpatient *UB-04* claim form or through ANSI 837I/837P transactions.

5. Which ICD-10 codes can I use to bill national code T1013?

The national procedure code indicates oral interpretive services, as well as sign language, and ICD-10 codes will be required for reimbursement. Please see the sign language interpreter services code conversion crosswalk for the most applicable ICD-10 codes to use when billing T1013.

6. What is a revenue code?

A revenue code identifies specific accommodations, ancillary service or unique billing calculations or arrangements. Revenue codes are four digits and accompany CPT Category I and HCPCS Level II national procedure code(s) billed on a claim.

7. Will revenue codes be required for all sign language interpreter services claims?

Revenue codes are not required when billing on *CMS-1500* claim forms or ANSI 837P transactions.

For dates of services on or after January 1, 2019, a four-digit revenue code must be included on outpatient claims billed on paper *UB-04* claim forms or ANSI 837I for electronic billing.

A UB revenue code is required when billing on a *UB-04* claim form or the 837-I transaction.

Outpatient claims with dates of service on or after January 1, 2019, which are submitted on paper *UB-04* claim forms or ANSI 837I transactions with missing, incomplete or invalid revenue codes will be denied.

Note: Revenue Code **0969 (Other Professional Fees)** is recommended to ensure compliance with HIPAA transactions; however, the submission of a revenue code other than the recommended code will not result in a claim denial.

See the *Medi-Cal Update* provider bulletins and *Newsflash* article Valid Revenue Codes Required for Outpatient Claims for additional information.

8. What is a modifier code?

Modifier codes are two-character codes used to supplement information or adjust care descriptions to provide extra details concerning a procedure or service provided by a physician. Modifiers help further describe a procedure code without changing its definition. Omitting or billing with incorrect modifiers can result in inaccuracies with provider reimbursement and health service records.

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9. What specific modifier(s) will I need to use to bill with the codes for sign language interpreter services claims?

Modifier code HM is to denote that the rendering provider is a certified Sign Language Interpreter. The physician currently bills these services on behalf of the sign language interpreter. Modifier code HM will be applicable for dates of service on or after January 1, 2019.

HM – Less than bachelor degree level

10. Is T1013 billed in increments?

Yes, T1013 is billed by units of time; which is identified according to the national procedure code descriptions. One unit equals 15 minutes. Fractions of units are calculated this way:

00 – 07 minutes equals 0 units, which is not payable

08 – 22 minutes equals 1 unit

23 – 37 minutes equals 2 units

38 – 52 minutes equals 3 units, etc.

National Procedure Code	Minutes/Unit	Maximum Billed
T1013	15 min/1 unit	32 Units = 8 hours

Note: Providers are instructed to bill a maximum of 32 units per day (8 hours).

11. Will I need to update my billing software?

Updates may be needed. It is recommended that providers inquire with their vendors and billing/system contractors to determine if any software changes will be needed, and make the necessary changes when applicable.

12. How do I test/validate that my system changes are compatible with the code conversion?

Submitters may test status to ensure accurate file format, completeness and validity for HIPAA-compliant claims transactions by logging into the Medi-Cal test site using their submitter ID and password. Instructions for Computer Media Claims (CMC) testing are found in the *Testing and Activation Procedures* section of the CMC Billing and Technical Manual.

13. Whom can I contact if I have additional questions or concerns?

Providers may request additional onsite or telephone support via the Telephone Service Center (TSC) at 1-800-541-5555, from 8 a.m. to 5 p.m., Monday through Friday, except holidays. Border Providers and Out-of-State Billers billing for In-State Providers call (916) 636-1200. Providers calling from outside of California call the Out-of-State Provider Unit at (916) 636-1960 from 8 a.m. to 12 p.m., Monday through Friday, except holidays.

For electronic claim submission questions, the CMC Help Desk can be accessed by calling the TSC at 1-800-541-5555 and select the option Point of Service (POS), Internet, Lab Service Reservation System (LSRS), and CMC inquiries.

All other questions for the sign language interpreter services code conversion may be submitted via email to CAMMISCodeConversion@conduent.com.